Memorandum

MIAMI-DADE COUNTY

Date: October 2, 2007

To: Honorable Chairman Bruno A. Barreiro
and Members, Board of County Commissioners

Agenda Item No. 8(O)(1)(F)

From: George M. Burgess
County Manager

Subject: Recommendation for Approval to Modify Contract No. 221B: Health Maintenance Organization Administrator

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RECOMMENDATION

It is recommended that the Board of County Commissioners approve a modification of the referenced contract with Public Health Trust (PHT) d/b/a JMH Health System (JMH) to include a Low Option HMO Plan as follows:

CONTRACT NO:	221B, Supplemental Agreement No. 7
CONTRACT TITLE:	Health Maintenance Organizations (HMO) Plan for Miami-Dade County and Public Health Trust/Jackson Health System Employees
DESCRIPTION:	To supply a Health Maintenance Organization (HMO) Administrator Plan for Miami-Dade and Public Health Trust employees and retirees.
PROJECT MANAGER:	Marsha Pascual, General Services Administration
ORIGINAL TERM:	Two years with options-to-renew on a year-to-year basis at the County's sole discretion.
CONTRACT AMOUNT:	The total County payment to the JMH Health Plan for FY 06-07 is approximately $6.7 million which includes the County contribution of $4.6 million as well as employee and retiree contributions of $2.1 million.
MODIFICATION AMOUNT:	The fiscal impact of this modification depends on how many employees select the low option HMO plan with JMH. The County contribution for premiums per enrolled employee will be $7,300 annually.
FUNDING SOURCE:	(a) The employee portion is paid through the Insurance Trust Fund and, (b) the dependent and retiree portions are paid entirely by employees and retirees.
METHOD OF AWARD:	At the March 4, 1999 Board of County Commissioners meeting, staff was directed to negotiate an agreement with JMH, an incumbent health care provider, for a two year period with unlimited options to renew. Options to renew have been exercised for plan years 2002 through 2007.

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USING/MANAGING AGENCY:	GSA - Risk Management Division
CONTRACT MEASURES:	Not applicable
AWARDED VENDOR:	Public Health Trust d/b/a JMH Health System
USER ACCESS PROGRAM:	The contract does not contain the 2% User Access Program provision since the UAP does not apply to employee health plans.

BACKGROUND

The JMH Healthplan currently offers an HMO product to County and PHT employees. The plan design closely resembles the "High Option" AvMed plan design approved by the Board of County Commissioners on July 10, 2007 (R-810-07). As part of that solicitation, the County created a new "Low Option HMO", which includes cost savings features such as higher co-payments and hospital deductibles in exchange for lower premiums. It also includes a gatekeeper provision which requires a referral from a primary care physician to visit a specialist.

JMH requested the opportunity to offer a "Low Option HMO" as well, in order to be competitive with the AvMed program. This supplement is to modify an existing agreement with JMH Healthplan in order to allow introduction of this second plan option for employees.

Assistant County Manager

MEMORANDUM

(Revised)

TO: Honorable Chairman Bruno A. Barreiro and Members, Board of County Commissioners

DATE: October 2, 2007

FROM: R. A. Cuevas, Jr. County Attorney

SUBJECT: Agenda Item No. 8(O)(1)(F)

Please note any items checked.

_____ "4-Day Rule" ("3-Day Rule" for committees) applicable if raised

_____ 6 weeks required between first reading and public hearing

_____ 4 weeks notification to municipal officials required prior to public hearing

_____ Decreases revenues or increases expenditures without balancing budget

_____ Budget required

_____ Statement of fiscal impact required

_____ Bid waiver requiring County Manager's written recommendation

_____ Ordinance creating a new board requires detailed County Manager's report for public hearing

_____ Housekeeping item (no policy decision required)

_____ No committee review

Approved _____ Mayor
Veto _____
Override _____

Agenda Item No. 8(O)(1)(F)
10-02-07

RESOLUTION NO. _____

RESOLUTION AUTHORIZING EXECUTION OF A MODIFICATION TO AGREEMENT NO. 221B WITH PUBLIC HEALTH TRUST D/B/A JMH HEALTH SYSTEM (JMH) TO INCLUDE A LOW OPTION HEALTH MAINTENANCE ORGANIZATION (HMO) PLAN, AUTHORIZING THE COUNTY MAYOR OR DESIGNEE TO EXECUTE A SUPPLEMENTAL AGREEMENT FOR AND ON BEHALF OF MIAMI-DADE COUNTY AND TO EXERCISE ANY CANCELLATION AND RENEWAL PROVISIONS, AND TO EXERCISE ALL OTHER RIGHTS CONTAINED THEREIN.

WHEREAS, this Board desires to accomplish the purposes outlined in the accompanying memorandum, a copy of which is incorporated herein by reference;

NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF COUNTY COMMISSIONERS OF MIAMI-DADE COUNTY, FLORIDA, that this Board approves the modification of Agreement 221B to include a low option HMO plan, in substantially the form attached hereto and made a part hereof, and authorizes the County Mayor or designee to execute same for and on behalf of Miami-Dade County and to exercise any cancellation and renewal provisions and any other rights contained therein.

The foregoing resolution was offered by Commissioner , who moved its adoption. The motion was seconded by Commissioner and upon being put to a vote, the vote was as follows:

Bruno A. Barreiro, Chairman
Barbara J. Jordan, Vice-Chairwoman

Jose "Pepe" Diaz	Audrey M. Edmonson
Carlos A. Gimenez	Sally A. Heyman
Joe A. Martinez	Dennis C. Moss
Dorrin D. Rolle	Natacha Seijas
Katy Sorenson	Rebeca Sosa
Sen. Javier D. Souto	

The Chairperson thereupon declared the resolution duly passed and adopted this 2nd day of October, 2007. This resolution shall become effective ten (10) days after the date of its adoption unless vetoed by the Mayor, and if vetoed, shall become effective only upon an override by this Board.

MIAMI-DADE COUNTY, FLORIDA
BY ITS BOARD OF COUNTY COMMISSIONERS

HARVEY RUVIN, CLERK

By:_____
Deputy Clerk

Approved by County Attorney as
to form and legal sufficiency.
Hugo Benitez

MIAMI-DADE COUNTY, FLORIDA

SUPPLEMENTAL AGREEMENT NO. 7

Contract Number: **221B - Approved by Resolution No. R-1022-99, Adopted September 21, 1999**

Contract Title: **"Health Maintenance Organization Administrator"**

Contractor: **Public Health Trust d/b/a JMH Health System**
1801 NW 9th Avenue
Suite #700
Miami, Florida 33136

In accordance with the above referenced Contract, this Supplemental Agreement No. 7, when properly executed, incorporates a revised Appendix A to the Agreement (attached hereto), which allows for the inclusion of a Low Option HMO Plan (with gatekeeper).

All terms, covenants and conditions of the original Contract and any Supplemental Agreements issued thereto shall remain in full force and effect, except to the extent herein amended.

IN WITNESS WHEREOF, the parties have executed this Supplemental Agreement to County Contract No. 221B effective as of the date herein above set forth.

Contractor	Miami-Dade County
By: Olga Dazzo	By:
Name: OLGA DAZZO	Name:
Title: Executive Director	Title:
Date: 9/20/07	Date:
Attest:	Attest:
Corporate Secretary/Notary	Clerk of the Board

Corporate Seal/Notary

Sworn + subscribed before me this 26th day of September, 2007. Before me appeared olga Dazzo whom is personally known to me to be the same person

Notary Public

Notary Public State of Florida
Amy Santana
My Commission DD506522
Expires 03/18/2010

APPENDIX A

SCOPE OF SERVICES

2.1 Introduction and Background

The County and the Public Health Trust/Jackson Health System employ approximately 40,000 individuals throughout South Florida. The covered groups include:

- Miami-Dade County
- Public Health Trust/Jackson Health System
- Retirees under age 65
- Retirees over age 65
- Judges
- Miami-Dade County Expressway Authority
- Industrial Development Authority
- Town of Miami Lakes

Additionally, the Dade County Association of Firefighters Local 1403 ("DCFF") offers a plan option to their employees. Employees will retain the opportunity to participate in any of the County plans or if eligible, the union plan.

2.2 General Information

2.2.1 Contractor shall provide a High Option HMO Plan and a Low Option HMO Plan. The Low Option HMO Plan includes cost savings features such as a gatekeeper and higher co-payments than the High Option HMO in exchange for lower premiums. Attached is a comparison of benefit highlights of the two plans.

2.2.2 The Contractor shall be a Florida licensed Health Maintenance Organization, a Florida-licensed Health Insurance Company, or any entity allowed under Florida Statutes to provide health care plans in the State of Florida.

2.2.2 Members of the DCFF Union may be eligible for coverage in their Union-sponsored plan.

2.2.3 The County offers a self-funded Point of Service (POS) plan, a High Option HMO and a Low Option HMO through a separate arrangement.

2.2.4 The County contributes 97% of the single employee cost for the POS plan and 100% of the employee cost for the HMO plan options. Employees contribute the difference between the County contribution for single coverage and dependent coverage. The employee contribution to the cost is offered on a pre-tax basis. Retirees contribute 100% of the cost of their coverage.

2.2.5 The County contribution levels are subject to collective bargaining agreements. If the bargaining process results in a change in contribution strategy, the rates proposed must remain valid.

2.2.6 Any full-time County employee who has completed 90 days of employment is eligible for plan coverage. Any part-time employee who consistently works at least 60 hours bi-weekly and has completed 90 continuous days of employment is also eligible. Coverage is effective the first

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day of the month following or coincident to completion of the eligibility period, providing an application is received without any actively at work exclusion. Executives, as identified by the County, are eligible for coverage on their first day of employment.

2.2.7 Employees under age 65 who retire with at least 6 years of active County service, and who have applied for pension benefits may continue HMO plan membership for themselves and their dependents until age 65 with remittance of the required premium to the County. The dependents of deceased retirees or of retirees attaining Medicare eligibility may continue coverage through the retiree group by remitting the appropriate premiums.

2.2.8 Employees 65 or over and retired employees who have attained age 65, and their dependents, may choose a Medicare Supplement or a Medicare Risk HMO with required premium remittance.

2.2.9 Retiring employees are provided a one-time opportunity at the time of retirement (no later than 30 days from the retirement date) to change their medical plan election in order to allow participation in the option which best meets their retirement needs. Retirees may participate in an annual open enrollment period.

2.2.10 Employee membership terminates on the last day of the pay period for which applicable payroll deductions are made after the date the employee ceases active work for any reason other than an approved leave of absence or retirement.

2.2.11 All underwriting requirements will conform to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), where applicable.

- ❖ New employees and their eligible dependents are eligible for coverage without proof of insurability and are not subject to pre-existing condition exclusions.
- ❖ Late enrollees who do not incur a HIPAA qualifying event may not enroll until the following annual enrollment period for the next January 1 effective date.
- ❖ All employees and dependents enrolled as of December 31, 2007 will be eligible for coverage with no actively at work exclusion.

2.2.12 Adding dependents. The following rules apply for adding dependents:

- ❖ New Dependents - A dependent may be added to the medical plan by submitting an application within 45 (60 days for newborns) days of acquiring the dependent. Coverage for a new spouse is effective the first day of the month following receipt of the application. Coverage for a new born, child placed for adoption, or adopted is effective as of the date of birth, placement for adoption, or adoption date. The change in premium, if applicable, is effective the first pay period of the month following birth, placement for adoption, or adoption.
- ❖ If eligible employees have declined coverage for themselves or their dependents because of other insurance coverage and the other coverage ends, they may request enrollment within 30 days after the other coverage ends.
- ❖ Change of Family Status - A dependent may be added to the Group Medical Plan program at anytime during the year under HIPAA provisions or IRS Section 125 Provisions. Proof of the change in family status must be submitted.

2.2.13 Employee membership terminates the last day of the pay period for which applicable payroll deductions are made after the date the employee ceases active work for any reason other than an approved leave of absence or retirement.

2.2.14 The Contractor shall accept eligibility data in an electronic format in the file layout used by the County.

2.2.15 The Contractor shall accept County employees and retirees enrolled in a County sponsored plan or a union-sponsored plan which becomes insolvent and impose no restriction on such membership.

2.2.14 The Contractor shall adhere to the Performance Standards as stated in Appendix E of the Agreement.

2.2.15 "Medical Necessity" is a defined term as stated in Contractor's Proposal.

2.2.16 The criteria for organ transplants in the HMO is defined in Contractor's Proposal.

2.2.17 The Contractor shall adhere to its system for the consideration of and the credentialing of physicians in its networks.

2.2.18 The Contractor shall adhere to the underwriting rationale and justification for its premium rate tier ratios.

2.2.19 The Contractor shall take necessary actions to prevent disparagement of the managed care program in which the provider participates.

2.2.20 Unless required by law, commissions to agents, brokers etc. shall not be included in any of Contractor's rates.

2.3 Enrollment/Communications Provisions

2.3.1 The Contractor shall provide sufficient enrollment materials for eligible employees/retirees during initial enrollment (at no additional cost to the County).

2.3.2 The Contractor shall provide printed booklets/certificates for all enrolled employees after initial enrollment, with additional supplies as required (at no additional cost to the County).

2.3.3 The Contractor shall provide I.D. cards to all enrolled employees and dependents; additionally ID cards will be generated and distributed within 15 business days, when any of the following events occur: Change on coverage option or group or a replacement/duplicate card is requested.

2.3.4 The Contractor shall be able to identify members by Social Security number, unless prohibited by Law.

2.3.5 The County must approve in writing all booklets and any/all other employee communications prior to printing. The Contractor shall distribute communication material to the County Departmental Personnel Representatives approximately 55 and approximately 10 PHT/JHS at various locations through out the County. The County retains the right to prohibit distribution of

any materials that make false or misleading statements, make reference to any plan other than the Contractor's plan, or any other materials or "give-aways" which the County deems to be inappropriate.

2.3.6 At least 60 days before the open enrollment effective date, the County will publish a benefit comparison schedule. The Contractor will have the opportunity to review and suggest changes to ensure the accuracy of the benefit information prior to publication. The County shall retain final approval authority over all communication material.

2.3.7 The County produces a standard enrollment form for open enrollment and new employees. The Contractor shall also accept the use of the County's Status Change Form for changes (e.g. additions and deletions) to the health plans. The County shall retain final approval authority of the standard enrollment form.

2.3.8 The Contractor's representatives shall be allowed access to County employees on County premises as determined by the County.

2.3.9 The County uses web enrollment for the annual open enrollment and anticipates continued use of web enrollment for ongoing enrollments.

2.3.10 The Contractor shall update electronic eligibility data within 24 hours (paper data within 48 hours) from the time of receipt of data.

2.3.11 The Contractor shall provide a single point of contact with regard to eligibility and enrollment information.

2.3.12 Contractors shall provide sufficient personnel to attend all initial enrollment period meetings and subsequent open enrollment period meetings on a schedule set by the County. The Contractors shall provide personnel to attend meetings scheduled by the County between such annual periods, assuming reasonable notice is given.

2.3.13 The Contractor shall adhere to an implementation schedule for a January 1, 2008 effective date, with enrollment scheduled for the fall of 2007.

2.4 Benefits Provisions

2.4.1 The Contractor's plan shall comply with federal guidelines for Cafeteria Plans pursuant to Internal Revenue Code Section 125, the Age Discrimination in Employment Act (ADEA), American Disabilities Act (ADA), Medicare Secondary Payor, Health Insurance Portability and Accountability Act of 1996 (HIPAA), and COBRA, as well as all Florida-mandated benefits.

2.4.2 The Contractor shall have a full service contract in place with the University of Miami/Jackson Memorial Medical Center (subject to the Contractor's standard credentialing methods) and such agreement shall be in place for the duration of any agreement in place with the County.

2.4.3 The County's Employee Support Services (ESS) shall have full authority to refer members to the health plan network for mental health/substance abuse services. The ESS shall bill and be reimbursed by the Contractor according to negotiated fees. The County's ESS providers shall be subject to the HMO Plan's credentialing process.

2.4.4 Wellness benefits should be available within the HMO. Each selected plan shall cooperate with the County in making health screenings readily available throughout the County. The Contractor shall participate with the County in various health-fairs, which may be made available to employees and families. In addition, the Contractor shall readily provide various wellness

activities including, but not limited to health fairs, flu shots and educational workshops.

2.5 Data Provisions

2.5.1 The Contractor shall provide the following reports (these reports must include the information as stated below):

- ❖ Quarterly Paid Claims Activity Reports - shall be segregated by active employees, Medicare and Non-Medicare eligible retirees, and further categorized with dependents and COBRA beneficiaries identified separately (active and retirees).
- ❖ Capitated Reports - where applicable, quarterly capitated reports shall show Primary Care Physicians (PCP), specialists and providers of other services. This report shall show capitation by category.
- ❖ Quarterly Medical Case Management Reports - on all claims expected to exceed $50,000 or otherwise identified as being the type of claim that will benefit from Medical Case Management.
- ❖ Annual Hospital Utilization Review Reports - showing admissions by hospital, days requested, days approved, and days saved.
- ❖ Quarterly Prescription Drug Management Reports - separately detailing name brand and generic drug usage. These Reports should include formulary use and approved non-formulary prescriptions.

2.5.2 On-line access to eligibility, census data and individual claim information shall be provided to the County's on-site HMO Plan representative, if an onsite representative is requested by the County.

2.6 Administration Provisions

2.6.1 All benefit plans shall be administered on a self-accounting premium rate remittance basis. Contractor must accept the County's generated self-billing statements.

2.6.2 The Contractor shall accept bi-weekly bank wire-transfers of premium payments, in conjunction with County paydays. Premiums are remitted in arrears. A grace period of 30 days for active and paid leave status employees shall be provided. The Contractor shall provide a 60 day grace period for the bi-weekly remittance of premiums for employees on "leave without pay" status.

2.6.3 For any extensions, at least 180 days prior to the County's open enrollment effective date for benefits, the Contractor shall provide the County with the premium rates by tier for the following year, along with a detailed explanation of the Contractor's underwriting/actuarial methodology used to determine the new rates.

2.6.4 The Contractor shall pursue Coordination of Benefits (COB) before payment of claims.

2.6.5 The Contractor shall administer appropriate procedures to carefully monitor the status of over-age unmarried dependent children (19 and over) to ensure satisfactory proof of eligibility is obtained and that coverage complies with Federal and State regulations, including COBRA status. Dependent children losing group coverage due to age or loss of dependent status must be notified of their COBRA rights. The Contractor shall notify the County within 60 days after the open enrollment effective date (January 1 of each year) of any discrepancies in eligibility including employee name, dependent to be deleted and any change in coverage level.

2.6.6 The Contractor shall provide all COBRA administration, including mailing of initial COBRA

notification after receiving notification of qualifying event from the County. The services required also include billing of beneficiaries and collection of appropriate premiums.

2.6.7 The Contractor shall provide HIPAA certificates of coverage.

2.6.8 The Contractor shall provide a local account representative (Miami-Dade and Broward County Area) with full account management capabilities. The account representative must be capable of assisting the County in the administration of the plan, obtaining service for employees, obtaining the appropriate resolution of claims problems, and in any other ways requested related to the Services. There are no exceptions allowed for this requirement.

2.6.9 If plan enrollment is at least 5,000 subscribers, and at the County's discretion, the Contractor shall provide an on-site customer service representative to be housed at the County administration building. The Contractor shall provide for computer terminal, or have the County provide one for a fee that will have call-up capabilities of employees' eligibility and claims information, provide customer service related functions, and assist in plan administration.

2.6.10 The Contractor shall provide its standard grievance procedure for member's claim disputes, when services are denied. Every new member will receive notification of a detailed explanation of grievance procedures within 30 days of the effective date of coverage.

2.6.11 The Contractor shall share in the cost (not to exceed $10,000) to conduct an annual member satisfaction survey. The survey will be conducted by an independent vendor selected by the County.

2.6.12 The Contractor shall share the cost (not to exceed $10,000) to conduct open enrollment including but not limited to costs to develop and print the benefit comparison chart, securing temporary help for filing applications, assisting with forms processing and the like.

2.6.13 The Contractor shall screen applications for dependent eligibility and notify the County of changes, if any, in premium deductions.Eligibility requirements for dependents are:

(a) The present spouse of a Subscriber, however, if a spouse is also an employee of Miami-Dade County/Public Health Trust, he/she is not eligible to be a Dependent. He/She must qualify as a Subscriber, or

(b) A Subscriber's unmarried natural child, stepchild, foster child, adopted child or child placed for adoption, or a child for whom the Subscriber has been appointed legal guardian, pursuant to a valid court order, and who is under the limiting age. The eligibility limiting age for a Dependent child is the end of the Calendar year in which such Dependent child reaches age nineteen (19) except as stated below. In the event a claim is denied for the stated reason that the child attained the eligibility limiting age, it is the Subscriber's sole responsibility to establish that the child meets the applicable requirements for extended eligibility. Additionally, the Contractor may require acceptable documentation that the child meets and continues to meet such requirements at any time.

A Dependent child (except for Foster Children in court-ordered custody or guardianship of the Subscriber) may be covered until the end of the Calendar Year in which the child reaches twenty-five (25), if the child meets all the following requirements:

(i) The child is dependent upon the Subscriber for support and maintaining his/her primary residence in the Service Area: and

(ii) The child is living in the household of the Subscriber, or the child is a full-time or part-time student.

The extended eligibility will terminate on the last day of the pay period in which the child no longer meets the requirements for extended eligibility as a Dependent child.

Disabled Children

(iii) Coverage for an unmarried dependent child may be continued beyond age 25 if the child is mentally or physically disabled. Proof of disability shall be required.

2.6.14 The Contractor shall verify dependent eligibility at initial enrollment and at subsequent open enrollments, and notify the County within 60 days after Open Enrollment Effective Date (January 1 of each year) of any discrepancies in eligibility. The Contractor shall verify dependent eligibility for new hires and new enrollees within 60 days of the coverage effective date and notify the County of any discrepancies in eligibility.

2.6.15 The Contractor shall perform a biweekly reconciliation of accounts based on biweekly electronic eligibility files provided by the County. The Contractor shall notify the County within 10 business days of any discrepancies, to include subscriber name, subscriber identification number, name of ineligible dependent(s) and change in coverage level, if any.

2008 BENEFIT COMPARISON

	JMH HEALTH PLAN HIGH OPTION (HMO) **Visit our website at www.jmhhp.com**	JMH HEALTH PLAN LOW OPTION (HMO) **Visit our website at www.jmhhp.com**
COVERAGE PLAN DESCRIPTION	The JMH Health Plan offers Miami-Dade County employees "no-referral" access to more than 4,000 doctors across South Florida through our Premier Access Network, not to mention a list of hospitals, ambulatory surgical centers, outpatient diagnostic centers and urgent care centers that blanket Miami-Dade and Broward counties. Members are required to select a primary care physician. Other benefits include health and wellness discount programs, access to a 24-hour on-call nurse, and three months of prescriptions for the price of two – right at your local participating pharmacy. The JMH Health Plan is a not for profit, full service health maintenance organization.	The JMH Health Plan offers Miami-Dade County employees access to more than 4,000 doctors across South Florida through our Premier Access Network that blankets Miami-Dade and Broward counties. Members are required to select a primary care physician and referrals are required to see a specialist. Other benefits include health and wellness discount programs, access to a 24-hour on-call nurse, and three months of prescriptions for the price of two – right at your local participating pharmacy. The JMH Health Plan is a not for profit, full service health maintenance organization.
DEDUCTIBLES/CO-PAYMENTS	Co-payments $10 Physician office visit $0 Hospital admission co-pay $50 Emergency Room (waived if admitted) $7/$20/$35 Prescriptions for 30 day supply - Open Formulary Mail Order: $14/$40/$70 for 90 day supply	Co-payments $25 Physician office visit $150/day Hospital admission co-pay; max $450 per/adm. $100 Emergency Room (~~not~~ waived if admitted) $15/$30/$50 Prescriptions for 30 day supply - Open Formulary Mail Order: $30/$60/$100 for 90 day supply
PHYSICIANS	Choose any physician from the network of over 2,000 primary care physicians in Miami-Dade and Broward counties.	Choose any physician from the network of over 2,000 primary care physicians in Miami-Dade and Broward counties.
A. IN-HOSPITAL PHYSICIAN **Surgery/Visits & Consultations** **Anesthesiologist**	100%	100%
B. OUT-PATIENT PHYSICIAN SERVICES:		
Office visits for illness	$10 co-payment per visit, 100% thereafter	$25 co-payment per visit, 100% thereafter
Office visits for injury	$10 co-payment per visit, 100% thereafter	$25 co-payment per visit, 100% thereafter
Diagnostic X-Rays, Lab Tests, X-Ray treatments	100%	100%
Pediatrician **1) Medically Necessary**	1) $10 co-payment per visit.	1) $25 co-payment per visit.
2) Preventive (Child Health Supervision Services)	2) $10 co-payment per visit.	2) $25 co-payment per visit.

2008 BENEFIT COMPARISON

	JMH HEALTH PLAN HIGH OPTION (HMO)	JMH HEALTH PLAN LOW OPTION (HMO)
Routine Physical	$10 co-payment per visit.	$25 co-payment per visit.
Obstetrical/Gynecological	$10 co-payment per visit.	$25 co-payment per visit.
Hospitalization:	Benefits payable at 100% at following affiliated hospitals: **MIAMI-DADE COUNTY** Anne Bates Leach • Aventura • Baptist • Cedars • Coral Gables Hospital • Doctors Hospital •Hialeah Hospital • Jackson Memorial Hospital • Homestead Hospital • Holtz Children's Hospital • Jackson North Community Hospital • Jackson South Community Hospital • Kendall Regional • Kindred Hospital Coral Gables • Mercy Hospital • Miami Children's • Mt Sinai Medical Center • North Shore • Palmetto General • Palm Springs Hospital • South Miami Hospital• University of Miami/ Hospital & Clinic • West Gables BROWARD COUNTY Broward General Medical Center • Cleveland Clinic Hospital • Coral Springs Hospital • Florida Medical Center • Holy Cross Hospital • Hollywood Medical Center • Imperial Point • Joe DiMaggio Children's Medical Center • Kindred Hospital Ft Lauderdale • Memorial Hospital Miramar • Memorial Hospital Pembroke • Memorial Hospital West • Memorial Regional • North Ridge Medical Center • North Broward Medical Center • Northwest Medical Center • Plantation General • University Hospital • Westside Regional Medical Center	$150/day limit $450 per/adm at following affiliated hospitals: **MIAMI-DADE COUNTY** Anne Bates Leach • Aventura • Baptist • Cedars • Coral Gables Hospital • Doctors Hospital •Hialeah Hospital • Jackson Memorial Hospital • Homestead Hospital • Holtz Children's Hospital • Jackson North Community Hospital • Jackson South Community Hospital • Kendall Regional • Kindred Hospital Coral Gables • Mercy Hospital • Miami Children's • Mt Sinai Medical Center • North Shore • Palmetto General • Palm Springs Hospital • South Miami Hospital• University of Miami/ Hospital & Clinic • West Gables BROWARD COUNTY Broward General Medical Center • Cleveland Clinic Hospital • Coral Springs Hospital • Florida Medical Center • Holy Cross Hospital • Hollywood Medical Center • Imperial Point • Joe DiMaggio Children's Medical Center • Kindred Hospital Ft Lauderdale • Memorial Hospital Miramar • Memorial Hospital Pembroke • Memorial Hospital West • Memorial Regional • North Ridge Medical Center • North Broward Medical Center • Northwest Medical Center • Plantation General • University Hospital • Westside Regional Medical Center
Hospital/Surgical Requirements: Precertification of hospital confinements	All non-emergency inpatient confinements and physician charges are precertified through the JMH Health Plan.	All non-emergency inpatient confinements and physician charges are precertified through the JMH Health Plan.
Drug & Alcohol Treatment:		
Inpatient	Covered at 100% up to 30 days inpatient per year.	$150 per admission co-pay; max $450 per admission up to 30 days inpatient per year.
Outpatient	$10 co-payment per visit, limited to 60 outpatient visits per calendar year.	$10 co-payment per visit, limited to 60 outpatient visits per calendar year.
Mental & Nervous Disorders:		
Inpatient	Covered at 100% up to 30 days inpatient per year.	$150 per admission co-pay; max $450 per admission up to 30 days inpatient per year.
Outpatient	$10 co-payment per visit, limited to 30 outpatient visits per calendar year.	$10 co-payment per visit, limited to 30 outpatient visits per calendar year.

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2008 BENEFIT COMPARISON

	JMH HEALTH PLAN HIGH OPTION (HMO)	JMH HEALTH PLAN LOW OPTION (HMO)
Other Services **Ambulance** **Vision**	100% when medically necessary 100% for eye exam per 12 months.** $10 dispensing fee, 100% thereafter for select lenses and frames, for one pair of glasses per member per calendar year. Contact lenses not covered, 20% courtesy discount is available for professional fees and materials.	100% when medically necessary 100% for eye exam per 12 months.** $10 dispensing fee, 100% thereafter for select lenses and frames, for one pair of glasses per member per calendar year. Contact lenses not covered, 20% courtesy discount is available for professional fees and materials.
Prescription Drugs:	$7Generic/$20 Brand/$35/ Non-Formulary or refill up to 30-day supply including contraceptives, at CVS, Walgreens, Publix, Navarro, Sedanos, Albertson's, Wal-Mart, Winn Dixie, Costco, Medicine Shoppe, Sams, Kmart, and Target. See plan literature for other participating pharmacies. If member selects Brand when Generic is available, member pays difference in cost plus Brand co-payment. Retail or Mail order available 2 x co-payment for 90-day supply (Not all pharmacies participate).	$15Generic/$30 Brand/$50/ Non-Formulary or refill up to 30-day supply including contraceptives, at CVS, Walgreens, Publix, Navarro, Sedanos, Albertson's, Wal-Mart, Winn Dixie, Costco, Medicine Shoppe, Sams, Kmart, and Target. See plan literature for other participating pharmacies. If member selects Brand when Generic is available, member pays difference in cost plus Brand co-payment. Retail or Mail order available 2 x co-payment for 90-day supply (Not all pharmacies participate).
Durable Medical Equipment (DME):	100% of pre-authorized durable medical equipment, orthotic braces and prosthetics devices, obtained through a JMH Health Plan provider. $25 co-payment per medical condition. Maximum benefit $500 per year.****	100% of pre-authorized durable medical equipment, orthotic braces and prosthetics devices, obtained through a JMH Health Plan provider. $50 co-payment per medical condition. Maximum benefit $500 per year.****
Out of Area: **1) Emergency** **2) Non-Emergency**	100% after $50 co-payment (worldwide). Covered within the JMH Health Plan's Premier Access Network.	100% after $100 co-payment (worldwide). Covered within the JMH Health Plan's Premier Access Network.
	**See plan literature for details regarding vision benefits limitations and exclusions. ***See plan literature regarding purchase of non-Generic drugs. ****See plan literature for benefits and limitations of DME products.	**See plan literature for details regarding vision benefits limitations and exclusions. ***See plan literature regarding purchase of non-Generic drugs. ****See plan literature for benefits and limitations of DME products.